Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5403TLF	A. BUILDING _____ B. WING _____	06/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOUSE RECOVERY FOR MEN & WOMEN	2500 APRICOT LN LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	Initial Comments This findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the complaint investigation conducted at your facility on 6/30/09. This complaint investigation was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten residential program beds for transitional living for released offenders. The census at the time of the survey was nine. Three client files were reviewed. Complaint #NV00022300 was substantiated with deficiencies. Refer to Tag 9999	T 000		
T9999	Final Observations NRS 449.080 License: Issuance; validity; transferability. 2. A license applies only to the person to whom it is issued, is valid only for the premises described in the license and is not transferable. Based on observation, interview and record review on 6/30/09, the administrator allowed 3 of 9 residents to reside in a trailer that was not licensed or inspected during their initial licensure inspection on 10/3/08. Severity: 2 Scope: 3	T9999		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE